Colorado Health Partnerships, LLC

**Fiscal Year 2015**
**Quality Management and Utilization Management Program**
**Annual Evaluation**

## Executive Summary

The FY2015 annual evaluation was reviewed and approved by the Colorado Health Partnerships' Quality Improvement Steering Committee and Clinical Advisory/Utilization Management Committee (QISC/CAUMC) on September 11, 2015. The Class B Board members will complete their review of the annual evaluation in October, with final approval of the evaluation of quality activities and goals for FY2016 scheduled for the October 23, 2015 Class B Board meeting. Beacon policy and procedure requires the Quality Management and Clinical Directors to complete an evaluation of CHP's Quality Improvement and Utilization Management Programs on an annual basis. Colorado Health Partnerships' governing body requires that the QISC/CAUMC evaluate the annual QM/UM Work Plan and establish new or revised goals on an annual basis. Following approval by the QISC/CAUMC, the annual evaluation is submitted to the Beacon Company Quality Committee for review.

The CHP's QISC/CAUMC met 11 times during FY2015. Committee member participation in meetings has been consistent, averaging 90% during FY15, exceeding our standard of 75%. The Committee includes representation from all key areas: engagement center clinical, quality, medical and member/family affairs staff, and several providers.

The QISC/CAUMC made substantial progress toward achievement of the quality and utilization management goals identified in the FY15 QM/UM Work Plan, which are summarized throughout this document. Advancement on our work plan goals included the implementation of Substance Use Disorder (SUD) benefit, provider education and assistance, and SUD treatment record audits. CHP also implemented the SUD Clinical/Quality Subcommittee to evaluate the structure, processes, monitoring and outcomes associated with this new benefit.

Of note during FY15 is the continued increase in eligible members, along with a corresponding increase in the number of members needing services. While the final FY15 penetration rates haven't yet been calculated, in FY14 the number of members served increased 23.8% (9,689) compared to the previous year, and CHP's eligible members increased 21%. The significant increase in service requests is evident in some areas of performance, such as discharges per 1000 members.

Inpatient audits, along with other key audits were implemented in order to broaden the provider monitoring function. Evaluation of CHP's performance continues, with quarterly reviews of CMHC performance targets and measures by QISC/CAUMC, along with the development of new Quality and Performance Improvement Projects. CHP is currently engaged in two Quality Improvement Projects: Improving diabetes testing rates for Medicaid Members taking antipsychotic medication, and improving the rate of 7-day ambulatory follow-up after inpatient hospitalization for Medicaid Members. CHP also implemented one new Performance

Improvement Project focusing on the timely provision of behavioral health treatment for jail inmates transitioning back into the community who have a history of behavioral health needs.

The committee continued to review quarterly core performance measures, including behavioral health treatment engagement, ER visits, and inpatient admissions, follow-up after hospital discharge and hospital readmissions. .. The detailed review of performance measures resulted in continued monitoring of ambulatory follow up. Decreasing ambulatory follow up rates for seven-day follow up post discharge in FY2014 was a concern for the committee; thus, the Committee developed a quality improvement project which is referenced below.. The committee also continues to monitor the Top Five Diagnosis report for the use of the diagnosis Mood Disorder NOS, as well as to gain understanding into where the SUD diagnosis volume falls within the overall provision of treatment. This year's EQRO compliance review yielded excellent results. The accomplishments described above are a direct reflection of the active participation of the QISC/CAUMC members, and our commitment to working together as a partnership to accomplish our goals.

The QISC/CAUMC employs a variety of techniques to evaluate and improve performance and outcomes to identify potential performance/quality improvement initiatives. When available, the Committee compares performance to national benchmarks, performance of other BHOs or like organizations, and to previous year's performance. Statistical testing may be applied, when appropriate, to determine whether an increase or decrease in performance is truly (significantly) different, or whether the difference is due to random variation. Trending over time is also useful in showing where performance may be declining (or improving) even if testing doesn't show a significant difference from one time period to the next. When differences are detected, further analysis will occur. This may include analysis of more detailed or updated data, input from members or providers closely involved in the specific activity being evaluated to better understand what is occurring, or evaluation of circumstances or barriers that may be impacting performance. Once this process is completed, changes or interventions are often developed and implemented, and re-measurement occurs to determine whether the changes made have improved performance. The re-measurement is typically evaluated to determine whether the changes were effective, or whether more time, revision or additional change is necessary for improvement.

One of CHP's latest examples demonstrating the impact of this process are noted below; others are described throughout this document.

Emergency Room (ER) Visits: CHP continues to conduct analysis on ER visit data with the goal of reducing ER use. Over the last fiscal year the data showed that nearly 29% of ER visits were attributed to members who have not accessed behavioral health services and that most often there was only one visit for the majority of members. The data illustrates that in fiscal year 2015 86% of CHP members who accessed the ER only had one ER visit. This is based on 3,970 distinct members in FY2015 who had an ER visit.

CHP also continues to regularly monitor ER visits (per one thousand members) which did not result in a hospitalization through the review of the performance measure. The goal is to monitor the indicator quarterly based upon a rolling 12 month period. The data is then compared to the overall BHO rates. The average number of members who utilized the ER which did not result in a hospitalization in the most recent rolling annual period (April 2014 to March 2015) was 11 visits per one thousand members. This is a slight increase from the last rolling annual period which was 9.6 visits per one thousand members.

The Quality Management Department (QM Department) continues to reach out to Medicaid members and send letters to those members who had visited an ER at least twice and had not sought services from a behavioral health agency within six months prior to their latest ER visits. Included with the letters are reference materials for crisis lines. The aim is to inform members of the crisis services available and to re-direct the member to contact behavioral health crisis services in lieu of accessing the ER. During FY 2015, CMHC staff continued to receive monthly lists of Medicaid Members who had received the letters referenced

above so that they could contact and inform the Members about services their CMHCs offer. In addition, the CMHCs continue to notify clinicians and case managers about Medicaid members who are in treatment and have at least one emergency room visit that resulted in a primary DSM-IV diagnosis during the previous year. The clinicians or case managers discuss alternative services with the Medicaid members who are seeking care for non-life threatening concerns. Both of these ER visit interventions are ongoing
In addition, there was surprising information generated in regards to ER visits and the expansion population. In CY13 the number of ER visits was 1,982 and for CY14 the number of ER visits was 3,604. This is an 81.8% increase in ER visits from CY13 to CY14. However, CY13 and CY14 essentially have the same average of ER visits per member of 1.2 ER visits. Meaning that, while more members obtained services at the ER, it may be due to the numbers increasing with the addition of the expansion population. CHP will continue outreach to members who utilize the ER.

**Group Statistics**

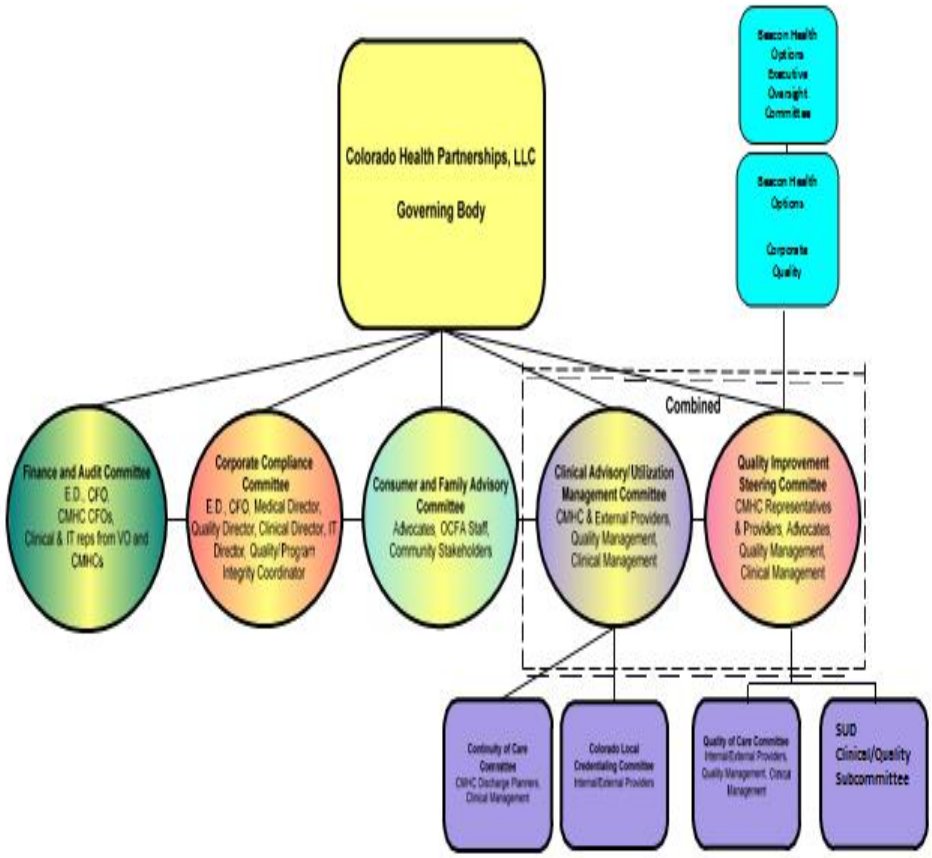
| | Calendar Year | N | Mean | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| ER Visits Per Member | CY14 | 2882 | 1.251 | .924 | .017 |
| | CY13 | 1591 | 1.245 | .887 | .022 |

While CHP's rate of ER visits per thousand members increased slightly as compared to the previous measurement year, the rate remained below the average rate for all behavioral health organizations.

An organizational chart of the CHP's Committee and Subcommittee structure is included below.

**ATTACHMENT C**

**Colorado Health Partnerships**
**Committee and Subcommittee Structure**



**Committee Descriptions**

Quality Improvement Steering Committee/Clinical Advisory/Utilization Management Committee (QISC/CAUMC)

The QISC/CAUMC is comprised of community agency providers, members and/or member representatives, and Beacon Colorado staff that represent a variety of cultural/ethnic groups, geographic regions, and the full range of disciplines, subspecialties, and areas of practice within CHP's catchment area. The QISC/CAUMC committee meets at a minimum on a quarterly basis in order to monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve patient care, and resolve potential issues. At any given meeting, trends are analyzed, deficiencies and barriers for improvement are identified, and solutions are recommended. Additionally, interventions are monitored for effectiveness and applicability. The QISC/CAUMC committee addresses a diversity of clinical and administrative issues including but not limited to; clinical treatment guidelines, utilization management guidelines, performance measurement and improvement activities, cross agency integration, and access issues. The QISC/CAUMC committee also reviews utilization management issues and indicators including monitoring and evaluating implementation of clinical guidelines, clinical criteria, and protocols. Furthermore, under and over-utilization issues are also monitored through the committee. CHP's Quality and Utilization Management Programs have a sound and sturdy history of process improvement and continue to advance due to the proactive involvement of stakeholders.

The QISC/CAUMC is comprised of community agency providers, members and/or member representatives, and Beacon Colorado staff that represent a variety of cultural/ethnic groups, geographic regions, and the full range of disciplines, subspecialties, and areas of practice within CHP's catchment area.

Colorado Local Credentialing Committee

The Colorado Local Credentialing Committee is chaired by the Medical Director and is comprised of providers representing the full range of disciplines, subspecialties, and areas of practice within the state. The Colorado Local Credentialing Committee meets monthly and provides input to Beacon National Credentialing Committee regarding statewide practitioners' credentialing and re-credentialing decisions. Colorado Local Credentialing Committee minutes are distributed to the QISC/CAUMC.

Quality of Care Committee

The Quality of Care Committee (QOCC) is a sub-committee of the QISC/CAUMC. This committee meets monthly. The QOCC is chaired by the CHP Medical Director and is comprised of the Vice President of Quality Management, Provider Relations Director, Clinical Peer Advisor, and other appropriate staff. The purpose of this committee is to identify, investigate, monitor, resolve, and trend quality of care and patient safety issues, as well as patterns of poor quality within our system. Activities include a review of care issues related to adverse incidents, over- and under-utilization, repeated non-compliance with access standards, deviations from standards of care, and treatment/discharge planning and medication management, along with other identified quality of care issues. Identified trends in care issues may result in corrective actions, education, or other activities designed to improve care.

Access and Continuity of Care Committee

The CHP Access and Continuity of Care Committee is comprised of BHO and regional provider representatives involved in assuring continuity of care for Medicaid members, including evaluation

and admission to inpatient care and discharge planning/oversight of the transition from inpatient to outpatient services. The Committee reviews issues and concerns that occur in the continuity of care process, problem-solves, shares ideas and current information, and proposes and enacts solutions.

Performance and Quality Improvement Projects

In addition to review and discussion at the QISC/CAUMC meeting, CHP has also established a PIP Task Group that meets at least quarterly – more frequently when needed. The purpose of the PIP Task Group is to achieve more focused, in-depth analysis of opportunities, barriers, ideas, and feedback related to performance improvement initiatives. The group's tasks consist of analyzing PIP related data, identifying opportunities and barriers to improvement, examining the successes and challenges of interventions, working toward the development of new PIPs or other quality improvement projects. The current PIP is summarized below.

Transitions of Care from the Local Jail Setting to the Community

CHP began a new Performance Improvement Project in 2014. This study, assigned by the State of Colorado's Department of Healthcare Policy and Financing (HCPF), is a collaborative, state-wide study designed to achieve the overall goal of improving transitions of care within the healthcare delivery system. The specific focus of the state-chosen topic is the transition of care from the local jail setting to the community. The question CHP is seeking to answer is, "Do targeted interventions increase the percentage of Medicaid Members with a behavioral health diagnosis and who were released from jail having an outpatient follow-up visit within 30 days of the release date?" This study question and methodology were approved by HCPF - 100% of evaluation elements received a score of "Met" in their PIP Validation Study. CHP is currently collecting inmate booking and release data from the participating jails, and the baseline will be calculated after data collection is complete.

Quality Improvement Project: Improving the rate of 7-day ambulatory follow-up after inpatient hospitalization for Medicaid Members.

Members who are hospitalized with a mental health diagnosis are a high-risk population, representing the most severely ill psychiatric patient population. Hospitalized Members exhibit the most serious of risk behaviors, including potentially violent behavior directed at themselves or others as well as the inability to provide for their own basic needs. During the hospitalization, the Members' symptoms are stabilized and a plan for continuing care becomes a vital step in the recovery process. An ambulatory follow-up visit with a mental health practitioner after discharge is necessary to ensure that gains made during hospitalization are not lost.

Analysis of 2013 CHP data indicates that only 48.6% of inpatient mental health hospitalization discharges were followed by an outpatient behavioral health service within seven days of Member discharge. CHP has consistently aimed to improve the connectedness between inpatient and outpatient providers, and the follow-up measure is an important metric of the capacity to serve our most severely ill psychiatric patient population by improving continuity of care and information transfers. Focusing on this measure allows CHP to identify providers that are performing well and learn from their processes as a means for collecting and disseminating best practices throughout the network, while identifying poor performing providers that require improvement strategies to ensure Members are receiving the standards of care that CHP upholds.

The goal is to improve the 7-day ambulatory follow-up rate for non-State hospitals from 48.6% to 54.5% by December 2016. The first remeasure year (calendar year 2015) yielded essentially the same follow-up rate as the baseline year (2014) – the rate decreased slightly to 47.0%, though this change was not statistically significant. With CHP as a Behavioral Health Organization (BHO) in Colorado, a Medicaid expansion state,

there was uncertainty regarding how the number of hospital admissions/discharges might fluctuate with an increase in Medicaid Members. If the number of discharges increased drastically after Medicaid expansion, then capacity issues might need to be resolved in order to keep up with and increase the follow-up rate. From 2013 to 2014 there was a 60% increase in the number of hospital discharges that met study criteria. CHP's Community Mental Health Centers (CMHCs) responded by hiring additional discharge planners and updating follow-up plans; however, with the lag in receiving claims data, problems for some CMHCs were not discovered until 6 -9 months after they began. CHP reviews data quarterly to stay apprised of shifts in follow-up and is confident that the goal of 54.5% will be reached by the targeted date.

Quality Improvement Project: Improving diabetes testing rates for Medicaid Members taking antipsychotic medication.

Colorado Health Partnerships (CHP) sought to focus on integration of behavioral and physical healthcare – developing a study that would facilitate communication between mental and physical health providers. An analysis of 2013 CHP data showed that 77.0% of consumers who were taking antipsychotic medications throughout the year completed diabetes testing (i.e., glucose or Hemoglobin A1C (HbA1C)) within that year. CHP believes that the percentage can be increased with targeted interventions. Several of the Community Mental Health Centers (CMHCs) in the CHP region have sites with medical providers (for example, nurses and physician assistants) located at the same physical locations as the behavioral health providers, so onsite diabetes testing is possible for many consumers. CHP will reach out to consumers as well as on- and off-site physical health providers to help ensure that consumers have diabetes testing done annually as recommended by the American Diabetes Association.

The goal is to improve the diabetes testing rate for Members who are regularly taking antipsychotics from 77.0% to 80.9% by December 2016. The first remeasure year (calendar year 2015) yielded a slight increase in diabetes testing rate compared to the baseline year (2014) – the rate increased from 77.0% to 77.9%. Interventions for 2015 include working with the physical healthcare Care Coordinators and/or providers to coordinate efforts in getting diabetes testing completed for all Members who need it. CHP reviews data every 6 months to assess the need for additional interventions and is confident that the goal of 80.9% will be reached by the targeted date.

## Measures of Performance

CHP's QISC/CAUMC Committee completed a review of the FY14 performance measures that are submitted to HCPF annually. The Committee review includes a comparison to the previous year's performance, as well as a comparison to the performance of other BHOs and national standards, where applicable. Core performance measures, as well as other indicators of performance designated by Committee or Committee Chairs, are presented to the Committee via a quarterly dashboard, using rolling annual data that is updated each quarter. This allows improved tracking and comparison of performance, and facilitates more timely interventions and Committee evaluation of the success of those interventions, furthering the goals of the Quality Management Program. CHP's QISC/CAUMC has also implemented performance targets for the CMHCs as part of the QM Work Plan. Performance targets are based on the BHO average for the previous year, and are monitored quarterly. If statistically significant variation from the target occurs for two consecutive quarters, corrective actions are requested. There were instances in which corrective actions were requested and submitted; the QISC/CAUMC continues to monitor for improvement. Data lags may impact the length of time necessary to see improvements take effect. The summary of performance measures below includes information on some of the more recent trends seen in the updated quarterly report.

In addition, current reports on performance measures are presented in the Access and Continuity of Care meetings. CHP leadership in the areas of discharge planning and crisis team evaluations attends this meeting

on a regular basis. Providing regular feedback gives opportunity for these measures to inform practice and allows the leadership at the mental health centers to support performance improvement and to be aware of and address any problem areas in a timely manner. Performance measure highlights are noted below.

**Discharges per Thousand Members:** The all hospital discharge rate per 1,000 members for FY15 (3rd Quarter measurement was 4.74 discharges per 1,000 members) was lower than the FY14 discharge rates (5.28 discharges per 1,000 members). CHP's FY15 rate is lower than the average rate across BHOs for FY14 (weighted average, all hospitals was 5.08). The CHP rate has been steadily declining over the past three quarters of rolling annual periods. Within the past several months, several mental health centers developed intensive community-based programs that diverted Members from hospitalization or residential treatment to more appropriate levels of care. The CMHCs will continue these programs.

**Average Length of Stay:** The overall average length of stay (ALOS) for both state and non-state hospitals during FY15 (3rd Quarter measurement) decreased from the ALOS for the prior fiscal year. . The length of stay for non-state hospitals and state hospital admissions was below the state average across all age groups. There is some variation across age groups, with the 65 years and older age group recording the longest average length of stay. This trend is most apparent when looking at the group that includes both state and non-state hospitals. A relatively small number of lengthy state hospital stays have influenced this metric. Clinical analyses of these longer stays indicate that they most often occur when there is a co-morbid physical condition that complicates discharge planning or when discharge back to a nursing home or assisted living facility is needed.

**Seven-day Follow-up Post Inpatient Discharge:** The overall follow-up rate within seven days of hospital discharge for both state and non-state hospitals midway through the fiscal year (3rd Quarter measurement) was above (i.e., better than) the statewide BHO average for the prior fiscal year and slightly above CHP's performance during FY14. Committee discussions regarding CHP performance and associated barriers occurred, including the provision of services not included in the measure, such as case management. Work continues regarding flexible appointment scheduling, potential involvement of peers in the hospital transition process, and other efforts to strengthen performance.

**Thirty-day Follow-up Post Inpatient Discharge:** The overall follow-up rate within 30 days of hospital discharge during the most recent 12-month measurement period (through December 2014) was slightly lower than CHP's FY14 performance; however, slightly higher than the prior year's state-wide BHO average. The rates are significantly higher within 30 days (66.1% for both non-state hospitals and all hospitals combined) than within seven days (47.0% for non-state; 46.6% for all hospitals). Additional efforts to engage members during the hospital transition process are currently being evaluated. The discussions described above for the seven-day follow-up measure also apply to this measure.

**Hospital Recidivism:** For the last 12 month measurement period (through December 2014), CHP's overall readmission rate within seven days of hospital discharge is 3.0%. This figure is somewhat lower (i.e., better) than the previous year's rate for both state and non-state hospitals as well as, the statewide BHO average (3.18%). CHP's overall 30-day readmission rate for the most recent 12 month measurement period is 9.0%. This is below the statewide average for FY14 (9.61%). CHP's 90-day readmission rate (15.0%; Q3 measurement) for this fiscal year is slightly lower than the statewide FY14 BHO average for all hospitals across all age groups (15.98). Readmission rates will continue to be an important focus during the next fiscal year.

**Emergency Room Visits per Thousand:** CHP's emergency room visit rate trended upward slightly in the last two quarters of calendar year 2014. Despite this trend, CHP's performance on this measure was still better (i.e., lower) than the statewide weighted BHO average for the prior year. Efforts to reduce emergency room visits continue, and CHP is hopeful that increased integration of behavioral health and medical services

will positively impact this utilization.

**Additional Quality Management Activities and Accomplishments:** Over the past year, CHP's Quality Program accomplished many objectives and also targeted some areas to initiate measurement and improvement. CHP's project to improve the rate of diabetes testing for Members taking antipsychotics is heading in the right direction. The first remeasure was calculated in July 2015, and the goal is set to be reached for the July 2017 measurement; thus, the Committee is still in the process of identifying interventions and best practices.

Additional accomplishments and activities include:

- Continuation of a Peer Services survey designed to gather more information on the perceived value of Peer Services
- Continued focus and outreach efforts to reduce ER use,
- A successful and informative EQRO compliance site review netting an overall score of 91%,
- Full implementation of Provider Performance Measure Targets,
- Continued focus on coordination of care for members and associated documentation audits,
- Initiated a new performance improvement project which is focused on increasing the number of members who have not received an A1C test in the past year and are currently prescribed atypical anti-psychotic medications,
- Implementation of the Substance Use Disorder benefit IPN audits ,
- Implementation of regularly occurring Inpatient audits,
- Development of an improvement activity focused on improving follow-up after hospitalization,
- Development of the State wide Performance Improvement Project focused on transitions of care, and
- Continued quarterly review by the QISC/CAUMC committee of the CHP Work Plan to ensure a comprehensive completion and attention to all Work Plan goals.

## Colorado Health Partnerships (CHP) Evidence-based Practices (EBP)

Beginning in FY15 CHP initiated several new EBP's for the adult and youth populations. Listed below are descriptions of the EBP's as well as information taken from the EBP Annual Evaluation. The annual evaluation examines numerous domains which provide insight as to the overall effectiveness, areas of shortcomings and areas of success for the specific EBP's.

### CHP Adult EBP's

Listed below are the six adult EBP's (bolded), with the individual EBP description and annual evaluation comments listed after the title. Summary information is included to highlight successes or issues specific to the EBP. Adult outcomes were assessed using a variety of outcome measurement tools which are referenced in the write up's below.

### Seeking Safety

Seeking Safety is a present-focused treatment for Members with a history of trauma and substance use disorder. This treatment modality was designed for flexible use and can be conducted in a variety of settings to include inpatient, outpatient and residential settings. The key principles of Seeking Safety are helping Members attain safety in their relationships, thinking, behavior, and emotions. This intervention concurrently addresses both PTSD and other behavioral disorders, and substance use disorder. Focusing on coping skills and psycho-education, Seeking Safety has five key principles: (1) safety as the overarching goal (helping Members attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment

(working on both posttraumatic stress disorder (PTSD) and substance use disorder at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance use disorder; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

**CMHC Participants:**

- Mind Springs Health
- Solvista Health
- San Luis Valley Behavioral Health Group

**Annual Evaluation Results:**

Seeking Safety for the adult population began in July 2014 taking place in the Western and Southern regions. This EBP was currently implemented by the CMHC's listed. All CMHC's used the Seeking Safety-2 (SS2) and the Seeking Safety-2 Spanish (SS2_Spanish) form to assess recovery outcomes. This two-question form addressed the participant's view of their current mental health status and how they felt about their ability to participate in relationships. This questionnaire was given at pre-EBP and post-EBP intervals. The goal was to show a positive trend in responses. Two out of the three CMHC's found that this EBP mostly met the needs of the population. Once CMHC encountered a barrier which surrounded staff not being consistent in following the process for referral and enrollment, which impacted tracking client participation in this group. An intervention to address this issue was established to allow all staff involved in the process to undergo retraining to address the importance of tracking client participation for state reporting. The CMHC's found that engagement for the group is a notable area of effectiveness. All CMHC's will continue this EBP throughout the next fiscal year.

**DBT**

DBT is a psychosocial treatment developed by Marsha M. Linehan specifically to treat individuals with borderline personality traits, substance use disorder, those with histories of self-harming behaviors, and is used with Members with other diagnoses as well. Clinical populations for which DBT has been determined to be effective are associated with high rates of trauma. The treatment is based largely in behaviorist theory with some cognitive therapy elements as well. Unlike cognitive therapy, it incorporates mindfulness practice and distress tolerance as central components of the therapy. Two essential parts of the treatment—individual and group—occur simultaneously.

**CMHC Participants:**

- San Luis Valley Behavioral Health Group
- AspenPointe
- Southeast Health Group
- The Center for Mental Health

**Annual Evaluation Results:**

DBT for the adult population began in July 2014 taking place in the Western, Southern and Pikes Peak regions. This EBP was already in place for three out of the four CMHC's listed. The Center for Mental Health was the only center to newly implement this EBP. All CMHC's used the PHQ-9 and the PHQ-9 Spanish form to assess recovery outcomes. This nine-question form measured the participant's severity of depression. Results were used to set up treatment goals. Common barriers to this EBP included lack of follow through with the program as well as continued engagement with participants was found to be difficult. In addition, centers found that when the EBP was implemented clients displayed a decrease in symptoms and an increased functioning outside of the group. All CMHC's agreed to continue this EBP due to the positive effects on the program attendees.

**Mental Health First Aid**
Mental Health First Aid is an adult public education program designed to improve knowledge and modify attitudes and perceptions about mental health and related issues in the general population, including how to respond to individuals who are experiencing one or more acute mental health crises (i.e., suicidal thoughts and/or behavior, acute stress reaction, panic attacks, and/or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (i.e., depressive, anxiety, and/or psychotic disorders, which may occur with substance use disorders).

**CMHC Participants:**

- The Center for Mental Health
- AspenPointe
- Spanish Peaks Behavioral Health Centers
- Mind Springs Health

**Annual Evaluation Results:**
Mental Health First Aid for the adult population began in July 2014 taking place in the Western, Southern and Pikes Peak regions. This EBP was currently implemented by three out of the four CMHC's listed AspenPointe was the only center to newly implement this ebp. All CMHC's used the total number of people trained in this technique in order to address EBP implementation. Feedback has been positive. CHP's Education Coordinator has also been providing Mental Health First Aid Training, and was recently certified in Mental Health First Aid for Older Adults.

**Motivational Interviewing**
Motivational Interviewing (MI) targets Member activation for change for those who have ambivalent attitudes or lack of resolve, which keeps them from correcting problem behaviors. MI can be applied to an array of problem behaviors, such as lifestyle issues affecting health, substance use disorder, medical treatment adherence, and mental health issues. MI includes elements such as assessing the Member's own motivations for change, eliciting the realization that current behavior and desired life goals clash, and developing an action plan with which the Member is willing to follow. One CMHC noted that an area of general effectiveness was that, that the flexibility of this EBP allows for the training to occur in various locations. Both CMHC's listed that this EBP mostly meets the needs of the population served and that they will continue the EBP into the next year.

**CMHC Participants:**

- Spanish Peaks Behavioral Health Centers
- Mind Springs Health

**Annual Evaluation Results:**
Motivational Interviewing (MI) for the adult population began in January 2015 taking place in the Western and Southern regions. This EBP was currently implemented by both CMHC's. Both CMHC's used the total number of people trained in this technique in order to address EBP implementation. One center found that the EBP mostly met the needs of the population and the other found that the EBP completely met the needs of the population served. Both centers will continue this EBP into the next year.

**Treatment of Depression in Older Adults/IMPACT**

Both of these important evidence-based practices address depression in the older adult population. Depression in older adults is often under diagnosed because its presentation can be confounded by symptoms related to normal aging or dementia. The Treatment of Depression in Older Adults Program is an EBP that provides treatment and services to improve outcomes for older adults with depression. Treatment interventions are dependent upon the older adult's specific challenges, desired outcomes, and preferred course(s) of action, but can include psychotherapy interventions, antidepressant medications, multidisciplinary outreach services, and/or collaborative and integrated physical and mental health care (IMPACT). IMPACT is an integrated evidence-based practice that provides treatment and services to improve outcomes for older adult Medicaid Members (typically age 55+) diagnosed with major depression or dysthymia, often in conjunction with another major health problem. The Member's primary care provider works with a care manager to develop and implement a treatment plan that includes medications and/or psychotherapy.

**CMHC Participants:**

- Spanish Peaks Behavioral Health Centers
- Axis Health System
- Solvista

**Annual Evaluation Results:**

IMPACT was implemented in July 2015 as well as Treatment of Depression in Older Adults taking place in the Western region. IMPACT was currently in place at Axis Health System but was newly implemented at Spanish Peaks Behavioral Health Centers. Additionally, Treatment of Depression in Older Adults was a new EBP for Solvista as well. All CMHC's used the PHQ-9 (SS2) and the PHQ-9 Spanish form to assess recovery outcomes. This nine-question form measured the participant's severity of depression. Results were then used when setting up treatment goals for members. Seeing as how these EBP's were not implemented until the beginning of fiscal year 2016, data will be available next year on the EBP annual evaluation forms.

**Chronic Disease Self-Management**

The Chronic Disease Self-Management Program enhances treatment and disease-specific education by providing Members with skills to improve their own health management, and maintain active lives. This community-based program is effective with many types of chronic medical conditions. This six-week program covers the following subjects:

1. Techniques to deal with problems such as frustration, fatigue, pain, and isolation
2. Appropriate exercise for maintaining and improving strength, flexibility, and endurance
3. Appropriate use of medications
4. Communicating effectively with family, friends, and health professionals
5. Nutrition
6. Decision making
7. How to evaluate new treatments

Workshops are facilitated by two trained leaders, one or both of whom are typically non-health professionals with chronic diseases themselves.

**CMHC Participants:**

- Southeast Health Group
- AspenPointe
- Axis Health System

**Annual Evaluation Results:**
Chronic Disease Self-Management for the adult population began in July 2015 taking place in the Western, Southern and Pikes Peak regions. This EBP was currently implemented by two out of the three CMHC's listed. Southeast Health Group was the only center to newly implement this EBP. All CMHC's used the Participant pre and post assessment to assess recovery outcomes. A common thread that CMHC"s found to be a barrier was that member participation was diminished due to reasons such as members not answering their phones at scheduled call times or members failing to show up for class. CMHC's devised plans on how to conduct outreach to members to address participation. The effectiveness of the EBP was found to be in the flexibility of the program as well as members creating new relationships and learning how to create new supports within the community. CMHC's indicated the EBP mostly met the needs of the population served and have chosen to continue the EBP into the next fiscal year.

**Population Health Management/Chronic Disease Management**
Summary: As of July 2015, 271 members are currently participating in or have completed the TeleCare Chronic Disease Management Program. This program provides disease management services to members diagnosed with asthma, diabetes, chronic pain, or heart disease. TeleCare does extensive outreach to contact and engage members who are appropriate for this program, and also accepts referrals from mental health centers for members who are currently in treatment and could benefit from disease management services.

Reports describing outcomes for members with diabetes and those with asthma (the two highest volume diagnoses) are produced every six months. A summary from the most recent report (July 2015) is provided below.

**Diabetes Care Clients:** For members with tenure of six months, the Summary of Diabetes Self-Care Activities Measure improvement in self-care activities for four of the five areas measured. These areas are healthful diet, quality of diet, blood glucose testing, and foot care. The area of exercise showed improvement, but the increases of scores from pre-intervention to 6 months later were not statistically significantly different. SF-12 scores for this group indicate improvement in both physical and mental health summary scores; and, the score increases were statistically significantly different for physical health.

**Asthma Care Clients:** After approximately six months in the program, participants experienced improvement in physical limitation due to asthma and sleep disrupted by Asthma symptoms. The only increase that was statistically significant was that in physical limitation due to asthma. The shortness of breath and asthma control self-rated score declined very slightly after 6 months of intervention, but this result was not statistically significantly different. SF-12 scores indicated statistically significant improvement in physical health summary scores.

**Chronic Pain Clients:** Participants were assessed using the PEG Scale before entering the program and approximately 6 months later. The scores showed statistically significant improvement for all of the items on the scale. The items are pain intensity during past week, degree pain interfered with life enjoyment during past week, and degree pain interfered with general activity during past week. The participants were also assessed using the Dallas Pain Questionnaire (DPQ) that evaluates a client's perception of the degree chronic pain affects four aspects of life. Again, all areas showed improvement in scores from pre-intervention to approximately 6 months later. Scores for three of the four areas, interferes with daily activities, interferes with work and leisure activities, and hampers social activities, showed statistically significant improvement.

**CHP Youth EBPs**

Listed below are the six youth EBPs (bolded), with the individual EBP description and annual evaluation comments listed after the title. Summary information is included to highlight successes or issues specific to the EBP. Youth outcomes were assessed using a variety of outcome measurement tools which are referenced in the summaries below.

**DBT**

CHP uses DBT because it is a cognitive-behavioral treatment approach to treat youth with borderline personality traits, substance use disorders, defiant disorder, self-injurious behavior, depression, trauma, and particularly those with suicidal behavior. The treatment is based largely in behaviorist theory with some cognitive therapy elements as well. Unlike cognitive therapy, it incorporates mindfulness practice as a central component of the therapy. Two essential parts of the treatment—individual and group—occur simultaneously. Both focus on building skills to cope with stress, re-frame distressing events, manage distressing emotions, and develop interpersonal skills. DBT helps people validate their emotions and behaviors, examine those behaviors and emotions that have a negative impact on their lives and make a conscious effort to bring about positive changes.

Studies indicate teens with borderline personality traits and behaviors that have participated in DBT programs make fewer suicide attempts and enter the hospital less often than non-participants. DBT also is a promising practice for other kinds of individuals such as suicidal adolescents, older adults with depression, and women with eating disorders.

**CMHC Participants:**

- AspenPointe
- Solvista Health
- Southeast Health Group
- Axis Health System

**Annual Evaluation Results:**

DBT for the youth population began in July 2014 taking place in the Western, Southern and Pikes Peak regions. This EBP was currently implemented by three out of the four CMHC's listed. Southeast Health Group was the only center to newly implement this ebp. All CMHC's used the PHQ-A and the PHQ-A Spanish form to assess recovery outcomes. This form is a PHQ-9, modified for adolescents. The PHQ-A measures the participant's severity of depression. Results were then used when setting up treatment goals for members. A common barrier indicated on the annual evaluations surrounded member commitment. Many CMHC's listed that regular, continued attendance was a key issue. In order to address this barrier, CMHC's engaged in outreach if members missed sessions. All four CHMC's have indicated that this EBP either fully, mostly or partly met the needs of the population who are currently engaged in this ebp. All four CMHC's will continue this EBP into the next fiscal year.

**Motivational Interviewing**

Motivational Interviewing (MI) is a goal-directed, Member-centered counseling style for eliciting behavioral change by helping Members explore and resolve ambivalence. The operational assumption is that ambivalent attitudes or lack of resolve are the primary obstacles to behavioral change. MI has been applied to a wide range of problem behaviors related to alcohol and substance use disorders as well as health promotion, medical

treatment adherence, and mental health issues. Although many variations in technique exist, the MI counseling style generally includes the following elements:

1. Establishing rapport with the Member and listening reflectively
2. Asking open-ended questions to explore the Member's own motivations for change
3. Affirming the Member's change-related statements and efforts
4. Eliciting recognition of the gap between current behavior and desired life goals
5. Asking permission before providing information or advice
6. Responding to resistance without direct confrontation. (Resistance is used as a feedback signal to the therapist to adjust the approach.)
7. Encouraging the Member's self-efficacy for change
8. Developing an action plan to which the Member is willing to commit

**CMHC Participants:**

- The Center for Mental Health
- Southeast Health Group

**Annual Evaluation Results:**
Motivational Interviewing (MI) for the youth population began in July 2014 taking place in the Western and Southern region. This EBP was currently implemented by one of the two CMHC's. Southeast Health Group was the only center to implement this as a new EBP. Both CMHC's used the total number of therapists trained in this technique in order to address EBP implementation and have decided to continue the EBP.

**CBT & Trauma-Focused CBT**
CBT is perhaps one of the most frequently used psychotherapeutic orientations, with considerable research supporting its effectiveness and adaptability in clinical practice. As the name implies, CBT integrates the rationale and techniques from both cognitive therapy and behavioral therapy, taking advantage of their complimentary relationship.

Cognitive therapy has been applied to a broad range of problems including depression, anxiety, panic, fears, eating disorders, substance use disorder and personality problems. CBT helps people in the ways they think (the cognitive) and in the ways they act (the behavior). CBT is a research-based intervention, generally brief, and cost-effective psychotherapy for many behavioral health problems. CBT used in individual therapy as well as group settings, and the techniques are also commonly adapted for self-help or self-directed applications. Some therapies are more oriented towards predominately cognitive interventions while some are more behaviorally oriented. Our expected outcomes for this EBP include:

- Increase coping abilities and reduce the frequency and intensity of crises
- Increase self-confidence in managing illness
- Improve awareness to early warning signs and successfully implement a plan of action to prevent or reduce decompensation
- Improvement in overall quality of life as Members take charge of their conditions and pursue productive lives in the communities of their choice
- This practice will continue to be used throughout the CHP service delivery area in 2014 and can be used for the substance use disorder benefit as well.

**CMHC Participants:**

- Southeast Health Group

- San Luis Valley Behavioral Health Group
- Axis Health System

**Annual Evaluation Results:**
CBT & Trauma-Focused CBT was implemented in July 2014 taking place in the Western and Southern region. CBT & Trauma-Focused CBT is currently in place at San Luis Valley Behavioral Health Group. This EBP was newly implemented for Axis Health System and Southeast Health Group. . All CMHC's used the PHQ-A and the PHQ-A Spanish form to assess recovery outcomes. This form is a PHQ-9, modified for adolescents. The PHQ-A measures the participant's severity of depression. No major barriers were indicated by reporting CMHC's; however, one CMHC found that with some participants continued engagement in the program was difficult. Due to staff turnover and inconsistencies with staff following the process for referral and enrollment, two of the CMHC's were unable to fully complete their annual evaluations. All three CMHC's will continue this EBP for the next fiscal year.

**Love and Logic**
Love and Logic is a promising practice psycho-educational model that focuses on raising and teaching children and enabling parents to feel empowered and more skilled in their interactions with children. Love allows children to grow through their mistakes. Logic allows children to live with the consequences of their choices. It is a model that uses a win/win philosophy for the youth and the parent. Parents win by learning to show love in a healthy way and establish effective control. Youth win by learning responsibility through solving their own problems and acquiring tools for coping with the real world. One CMHC noted that no child care available and consistency in member attendance were notable barriers that were encountered. Both CMHC's will continue with this EBP.

**CMHC Participants:**
- Mind Springs Health
- Spanish Peaks

**Annual Evaluation Results:**
Love and Logic was implemented in July 2014 taking place in the Southern region. Both CMHC's currently have this EBP implemented as well as using the recovery assessment forms CHPY-4 and CHPY-4 Spanish. The CHPY-4 is a two question form which asks the adult caregiver how they would rate their child's mental health as well as their own ability to manage their child's behavior. This questionnaire was given at pre-EBP and post-EBP intervals. The goal was to show a positive trend in responses.

**Family Preservation**
CHP provides family-preservation services to a wide range of family systems, including biological families, kinship families, foster families, and adoptive families. This practice assists families to address major challenges and provide targeted interventions for family stabilization and improved home life. Family preservation services typically are short-term. They are designed to assist families in crisis by improving parenting and family functioning while keeping their child safe. These services build upon the conviction that many children can be safely protected and treated within their own homes when parents are provided with services and support and empowered to change their lives.

**CMHC Participants:**
- AspenPointe

- San Luis Valley Behavioral Health Group
- The Center for Mental health

**Annual Evaluation Results:**
Family Preservation was implemented in July 2014 taking place in the Western, Southern and Pikes Peak regions. All listed CMHC's currently have this EBP implemented as well as using the recovery assessment forms CHPY-4 and CHPY-4 Spanish. The CHPY-4 is a two question form which asks the adult caregiver how they would rate their child's mental health as well as their own ability to manage their child's behavior. This questionnaire was given at pre-EBP and post-EBP intervals. The goal was to show a positive trend in responses.

CMHC's listed that barriers to providing this EBP were that the provider failed to enter the member into the EBP group upon admission also there were issues with discharging the member from the EBP. Other barriers included staff not being consistent in following processes for referral and enrollment, which impacted tracking client participation in this group. One CMHC listed that consistent client involvement created barriers as well. Even with the listed barriers, CMHC's found that using data obtained in the CHPY 4 was a positive way to highlight success to members and that services that were provided in the home to families increased their access to services that otherwise were limited. Out of the three CMHC'c listed all have decided to continue with this EBP. One CMHC listed that the EBP mostly meets the MHC's population needs, another CMHC listed that the EBP partly meets the MHC's population needs and one CMHC was unable to record any results due to staff not being, "consistent in following process for referral and enrollment, which impacted tracking client participation in this group."

**Wrap Around**
The home-based wraparound services are tied to a high fidelity treatment model. The planning and provision of home-based services require a specific, individualized process focused on the resiliency, strengths, and needs of the youth, and the importance of the family in supporting the youth. CHP's home-based services incorporate several interventions, including strength-based assessments, mobile crisis services, case management, care coordination, and individualized support.

**CMHC Participants:**
- The Center for Mental Health
- Solvista Health

**Annual Evaluation Results:**
Wrap Around was implemented in July 2015 taking place in the Western and Southern regions. All listed CMHC's currently have this EBP implemented as well as using the recovery assessment forms CHPY-4 and CHPY-4 Spanish. The CHPY-4 is a two question form which asks the adult caregiver how they would rate their child's mental health as well as their own ability to manage their child's behavior. This questionnaire was given at pre-EBP and post-EBP intervals. The goal was to show a positive trend in responses. Although this particular EBP was not implemented officially until the beginning of fiscal year 2016, both CMHC's had been currently offering Wrap Around Services. It has been decided that both CMHC's will continue to provide this EBP into and through the next fiscal year because it has been shown to meet the needs of the population served at the CMHC's. Adding additional staff for family supports will be addressed by CMHC's in order to overcome barriers of capacity limits.

**Seeking Safety**
Seeking Safety is a present-focused treatment for Members with a history of trauma and substance use disorder. Seeking Safety is for those with post-traumatic stress disorder (PTSD) and substance use disorder. This treatment modality was designed for flexible use and can be conducted in a variety of settings to include inpatient, outpatient and residential settings. The key principles of Seeking Safety are helping Members attain safety in their relationships, thinking, behavior, and emotions. This intervention addresses both PTSD and substance use disorder concurrently. One CMHC encountered two barriers;one barrier was low group attendance. The CMHC will continue to provide education to the population as well as providing advertising and community outreach in order to increase group numbers. Both CMHC's found that this EBP mostly met the needs of the population served and plan to continue the EBP.

**CMHC Participants:**

- Mind Springs Health
- Spanish Peaks

**Annual Evaluation Results:**
Seeking Safety for the youth population began in January 2015, initiated in the Western region. This EBP was already in place for one of the two CMHC's listed. Spanish Peaks was the only CMHC to newly implement this EBP. Both CMHC's used the Seeking Safety-2 (SS2) and the Seeking Safety-2 Spanish (SS2_Spanish) form to assess recovery outcomes. This two-question form addressed the participants' current mental health status and how they felt about their ability to participate in relationships. This questionnaire was given at pre-EBP and post-EBP intervals. The goal was to show a positive trend in responses.

**Audits and Accreditation**

The annual FY14 –15 EQRO site review, evaluating compliance with contract requirements, was completed in January of 2015. CHP earned an overall compliance score of 100% in three out of the four sections reviewed. The overall score for CHP was 91%. CHP's score for the audit demonstrates CHP's dedication to striving for excellence, and received positive recognition in several areas. Health Services Advisory Group commented that,
"Member materials, including the member handbook, were written in easy-to-understand language. CHP developed a "simple word thesaurus" as a tool to assist with converting complex health plan jargon into 6th grade reading level language for member materials and communications. The handbook was well-organized and indexed to allow members to readily search for specific topics. CHP translated numerous written materials into Spanish, which were available for dissemination. CHP maintained member mailing lists of Spanish-speaking and English-speaking households and disseminated materials accordingly. CHP mailed all member materials within required time frames, including enrollment materials, the annual letter and privacy notice, and notice of significant change in benefits or other vital information (i.e., substance use disorder [SUD] benefits new in 2014).

CHP clearly communicated to providers the responsibility to distribute specific information to members at provider facilities. CHP supported providers in this process through the provision of materials and member advocates located at the partner community mental health centers (CMHCs).
Member advocates assisted members in understanding their rights and distributed vital member materials. Materials included grievance and appeal information, member handbooks, and other flyers and member communications. The annual on-site provider audit included monitoring the availability of member materials."

"The CHP website was easy to navigate and included visible links to much of the essential member

information. The website included a Spanish conversion tab and provided access to some member materials in Spanish, including the member handbook and many Achieve Solutions health information articles. Staff stated that members have accessed Spanish-translated Achieve Solutions articles in significantly increasing numbers over the past year. The member handbook and/or website included information on covered services, the Colorado Preferred Drug List (PDL), the Colorado Mental Health Treatment Act (CMHTA), community resources, grievance and appeal procedures, member rights, trainings, the Ombudsman, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, wrap-around services, advance directives, emergency services, and provider network directories. The provider directory included all required information, and staff stated that only providers accepting new patients are included in the directory. The member handbook stated that members do not have to pay for emergency or post stabilization services, and the Web-site included a link to CHP's post-stabilization policy."

The Service Center continues to regularly evaluate compliance with all requirements established by the Utilization Review Accreditation Commission (URAC) as part of our URAC accreditation.

**Quality of Care**

CHP undertakes a variety of activities aimed at evaluating and improving the quality of care for members. Provider treatment record documentation audits continue quarterly, along with provider education in areas where scores indicate problems are evident. If improvement is not seen, the corrective action process is initiated. Audits include a review of encounters/claims against the chart documentation.
Education on the topic of documentation was offered to providers throughout the fiscal year. Many providers had the opportunity to engage in specific discussions and ask clarifying questions. Feedback on the training indicated that providers found it very helpful.

Investigations of potential quality of care issues are conducted through the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring through the Quality of Care Committee. All quality of care issues are documented, as are results of investigations, and corrective actions are tracked and monitored. Reporting, investigation and tracking of adverse incidents through the CHP Quality Management Department continued during the past fiscal year. An adverse incident may feed into the quality of care process based on investigation results. All providers are required to report adverse incidents; CHP received 303 adverse incident reports during FY2015 Both of these care monitoring initiatives, along with treatment record reviews and training, are conducted with the goal of assuring members receive the best care possible.

The Clinical Department sets high standards for our telephone performance, with goals that include keeping the average speed of answer (ASA) for all calls under 30 seconds and to maintain a call abandonment rate of less than 3 percent. For FY15, the department showed consistently excellent performance. Our abandonment rate was under 1% for the entire year. Average speed of answer for all calls combined, including nights and weekends, was less than 7 seconds; averaging 6.5 seconds per call.

We continue to work closely with our after-hours team in the Texas Service center to ensure the quality of service our providers and members receive. The Clinical Director continues to serve as a liaison to keep the team updated and apprised on local issues that our partners face, and oversees the adherence to workflows and processes to insure consistency of services provided by the team.

**Integration**

Systems Integration initiatives are focused on improving the quality of life for CHP members, partners and providers by innovatively bringing together resources, systems and strategies for better health care. CHP strives to align care across the varied systems that currently exist across the CHP region, with the ultimate goal of

further integration of all health care for members. The initiatives involve staff from various departments who work together to accomplish this goal. The team has expanded successful integration efforts from previous years and begun a number of new endeavors focused on various stakeholder systems. Efforts to integrate physical healthcare providers and agencies with our expanded behavioral health services have increased .Promotion of the Child Psychiatric Access and Consultation for Kids program continued regionally, and the program was expanded. This program provides "curbside" psychiatric consultations to pediatricians dealing with behavioral disturbances in their patients. This valuable service bridged the gap between child psychiatric needs and the severe shortage of child psychiatrists. Over the past year, new pediatric practices were trained in this program and many of the practices that signed on to the program last year are now using the service much more frequently. One of the challenges encountered in expanding this program is signing up behavioral health practitioners who are willing to be trained in the program and accept the many referrals which are generated. Pediatricians want to know that if they identify behavioral health problems that are beyond their scope of practice there is a ready and available resource to which to refer families. An additional staff person was added to this program to increase recruitment of behavioral health practitioners.

Involvement with state and local Departments of Human Service (DHS) continues. Collaborative Management Entities (CMEs) have been expanded throughout the CHP area. Staff are actively involved in these efforts to coordinate services provided by schools, DHS, juvenile justice, Medicaid behavioral health, and other agencies to our most vulnerable families.

CHP is also involved in other CMEs in the area. These include the Bent/Otero/Crowley County CME, Teller County CME, Park County CME and the Kiowa/Prowers County CME. These CMEs are in rural areas and the issues and strategies are much different. We are also actively participating in planning efforts for a similar program in Pueblo County. The diversity of the CHP area requires our flexibility and creativity in serving local communities within the region. CHP continues its involvement in the SB 94 programs. These programs also coordinate services delivered by various agencies including Medicaid behavioral health, focusing more specifically on the juvenile justice population. Presentations have been done for local DHS and foster care groups regarding BHO services. At a statewide level staff participate in the state DHS Core Services Director's quarterly meetings, where BHO issues can be addressed immediately as they are identified, and supporting efforts to improve care systems for youth.

Integration with physical health care services continues to be a major focus, including staff participation in efforts such as the Teen and Unintended Pregnancy Prevention workgroup and Chaffee County Health Coalition illustrate this effort. Other examples include integration and joint training efforts with RCCOs that staff have conducted, and participation in the Worksite Wellness Work Team and Preventing Long Term illness Due to Obesity Workgroup. Mental Health First Aid trainings were delivered to large physical health care provider organizations such as Centura Health. CHP has also provided trainings to physical health care providers titled "A Primer in Behavioral Health Disorders". This presentation familiarizes physical health care providers with basic behavioral health diagnoses and their characteristics. The training emphasizes how individuals with behavioral health problems often present to physical health care providers. At times the only symptoms mentioned are physical symptoms. We discuss typical presentations and questions to ask to determine if there is a behavioral health component.

In addition to physical healthcare providers, CHP has increased the focus on the homeless population. We are actively involved in a workgroup with the Fort Lyon homeless program to assist in developing discharge and

care coordination procedures. It is imperative that after program participants complete this extensive program, they receive immediate and thorough follow up for both behavioral health and physical healthcare needs. We are actively assisting in developing workflows to assure this happens. In addition, Mental Health First Aid training was provided to the staff of the Marian House Soup Kitchen, Colorado Springs Police Homeless Outreach Team and Downtown Library staff (where many homeless people in Colorado Springs congregate).There is a high rate of severe and persistent mental illness among the homeless population.

CHP maintains an active presence at statewide meetings to contribute to the enhancement of behavioral health services throughout Colorado, including the CHCBS Rules Rewrite workgroup, Katie Beckett Waiver Exploration Workgroup, Colorado Opportunity Project, Person Centeredness Thinking Summit, and other projects as requested by state departments involved in behavioral health care for various stakeholder groups.

Long Term Services and Supports and aging services remain a priority. Staff are involved in the ALF Training Development workgroup addressing training issues for assisted living facilities sponsored by HCPF and has recommended Mental Health First Aid for Older Adults training. This is a good introductory course for staff in identifying and dealing with behavioral health issues in older adults. Other committees and workgroups attended include:

- the Senior Behavioral Health and Wellness Coalition
- the ADRC (Aging and Disability Resource Center- formerly ARCH) Council and the Senior Services Networking group
- ALF and nursing home stakeholders quarterly meeting

In addition monthly contacts are made to share information on current events in behavioral health delivery to the ALF and nursing home populations.

Training and education is an important focus for the Integration Department. Over the past year the team has provided multiple trainings to community groups and providers on topics such as;

- Accessing Medicaid Behavioral Health Services
- Motivational Interviewing
- the Long Term Services and Supports System
- Trauma Informed Care
- Suicide Assessment and Intervention
- Integration of Behavioral and Physical Health Care Services
- BHO Complaints and Grievances Process
- Covered Benefits Updates
- Mental Health First Aid.

In addition, team members have composed an LMS (learning management system) course on the six levels of integrated care and a glossary of integrated care terms that is now being made available on the Colorado Behavioral Healthcare Council (CBHC) website. CHP has also offered a course through the University of Massachusetts on Integrated Behavioral Healthcare and Case Management in Integrated Settings to over 150 participants in the CHP area. We are an active participant in assisting CBHC with designing an integrated care training curriculum specifically designed for the Colorado market.

CHP assists in coordinating services when member's needs cross system boundaries. Members with co-

occurring mental health and intellectual disabilities, or substance use issues and even physical health problems require special assistance at times. Staff work with and across the various systems involved to see that members' needs are being met. Coordination and integration of medical, I/DD, substance use and other services that are seamless to the member is our goal. CHP has been working with several local criminal justice agencies to advance continuity of behavioral health services for Medicaid members involved in the criminal justice system, with the Criminal Justice Services Coordinator leading the efforts A large component of the work with the criminal justice system involves data sharing arrangements which have the potential to automate much of the process of identifying members involved with the criminal justice system who have behavioral health needs. CHP has begun to collect data from public records to cross match with our behavioral health claims data. These data support our efforts to quickly engage releasing members with behavioral health needs and minimize disruption in services.

## Evaluation of Overall Effectiveness of the Quality Management Program

The QISC/CAUMC Committee is comprised of both clinical and quality leaders/providers, and leadership from the Office of Member and Family Affairs (OMFA). OMFA input on clinical and quality performance, projects, issues, and outcomes as well as updates of OMFA Committee activities continue to be valuable in defining Quality Management Program objectives and ensuring the member/family perspective is a tenet of the Quality Management Program. The diversity of membership is a great benefit, enhancing CHP's ability to address all aspects of concerns and issues, as well as facilitating an understanding of the provider and BHO roles, operations and requirements. CHP believes that this structure is not only vital to developing projects, but is also valid in developing improvement initiatives with interventions that have a greater likelihood of success; this same structure also lends itself to allowing CHP to more fully evaluate the impact of improvement efforts. For CHP, this multi-faceted approach to quality management enhances the strength of our treatment, performance and outcomes system.

The QISC/CAUMC Committee meets on an established monthly schedule. The committee's broad membership brings extensive clinical and operational knowledge and experience to our meetings. This diversity provides strength in managing the quality of care and service provided to CHP Medicaid members. In addition, the continued dedication of committee members, evident through the annual meeting participation percentage supports stability as well as consistency in committee operation.

CHP continues to demonstrate progress toward meeting Quality Management Program objectives, completing many of the planned quality management activities over the past year.
Following a QM/UM work plan review, detailing achievements, progress, and barriers for the goals and initiatives established for FY15, the committee believes that the Quality Management Program has demonstrated effectiveness. Increased frequency of performance monitoring increases the QISC/CAUMC Committee's ability to identify declining performance more quickly, and take action. For example, although member service utilization substantially increased, consistent with a significant increase in newly eligible Medicaid members, many measures of performance monitored by the committee showed improvement or remained steady. This has occurred even as providers strived to adapt to an increased demand for services, many of whom practice in areas of the state designated as health professional shortage areas. Where measures show significantly decreasing performance for two consecutive quarters, development and implementation of corrective actions are required.

Through the QM/UM Program evaluation process; the committee also identifies areas for bolstering performance, and the potential for new improvement opportunities. These opportunities are typically prioritized and translated into objectives for the upcoming fiscal year.

The Quality Management Program staff continues to build expertise in the area of program requirements, evaluation of service quality and associated treatment outcomes, and analytical and reporting techniques. This experience results in more sophisticated and accurate reporting, fresh, new ideas, cross-training of staff; and improved capability for data-based decision-making within the Quality Management Program.

Although achievements for this past year were significant, there were areas where the QM Department strived to make a stronger impact, such as improving transitions for Medicaid members releasing from prisons and jails, or discharging from inpatient care. . CHP has begun the Statewide PIP focusing on the transition of care initiative. In August of 2014 the CHP PIP task group along with the QISC/CAUMC Committee begun work on the PIP and will focus on positively impacting transitions of care for the population who are released from jails. CHP continues progress toward improving performance in completed ambulatory follow-up appointment rates. Noticing that seven-day ambulatory follow-up rates began to trend downward, the committee implemented a Quality Improvement Project and will continue to monitor the performance measures to determine the best practices for positive change, analyze barriers encountered, and initiate interventions accordingly. To support improvement in health, CHP began a new Quality Improvement Project focused on increasing the percentage of members receiving an A1C test in the past year and are currently taking atypical anti-psychotic medications.

**Evaluation of Overall Effectiveness of the Utilization Management Program**

Overall, the CHP UM program has been successful and effective. The committee structure described in the QM sections above has also been working well for the ongoing operations of the utilization management program. The Clinical Advisory/Utilization Management Committee (CAUMC) and the Quality of Care Committee (QOCC) have practitioner involvement and input that guarantees practical utilization management solutions for the BHO.

The UM program enjoys active leadership from the Medical Director and several members of the senior management team. Because the committee structure is set up as it is, leadership is also found through our Class B Board input, as this Board is comprised of Community Mental Health Center C.E.O.'s. In addition, the Team Lead for Service and System Integration, Clinical Peer Advisor and Clinical Director complement the leadership team, ensuring that both internal and external management issues are addressed efficiently and effectively.

The experienced Clinical team is a strength of the UM program, and increased specialization of roles within the team has led to improved performance. For example, our Clinical Services Supervisor focuses on supervision of the Clinical Service Assistants, Clinical Care Manager training and problem-resolution and process improvement. The Clinical Service Assistants continue to be a vital part of the UM program, allowing the Clinical Care Managers to focus less on administrative details and more on the UM decision making, which requires their clinical expertise and skills.

The Clinical team presently consists of 1.0 FTE Clinical Director, 1.0 FTE Clinical Services Supervisor, 5.0 FTE Clinical Care Managers, 2.5 FTE Intensive Case Managers 5.0 FTE Clinical Service Assistants and a 1.0 FTE Substance Use Disorder Coordinator. The Medical Department consists of the 1.0 FTE Medical Director and 1.0FTE Clinical Peer Advisor. The success of the UM program is largely attributed to this

diverse and well-seasoned staff. Stability of the team, a focus on continuous process improvement and stable relationships with providers ensured productive and efficient UM services.

The performance of the clinical department is further reflected in the various measures completed throughout the year. The following is a summary of the key measures.

| 2014-2015 | Q1 July-Sep | Q2 Oct-Dec | Q3 Jan-Mar | Q4 Apr-Jun |
|---|---|---|---|---|
| Initial Authorization<br><br>Content Audits | 100% | 100% | 100% | 89% |
| Initial Authorization<br><br>Timeliness Audits | 100% | 100% | 100% | 95% |
| Concurrent Review Authorization<br><br>Content Audits | 100% | 100% | 100% | 92% |
| Concurrent Review<br><br>Timeliness Audits | 94% | 100% | 100% | 96% |
| Average Speed of Answer | 5.7 seconds | 6.2 seconds | 7.4 seconds | 6.7 seconds |
| Abandonment Rate (over 30 seconds) | 0.31% | 0.28 | 0.31% | 0.33% |
| Annual Inter-rater reliability survey | NA | 100% | NA | NA |

## Evaluation of FY2015 Goals and Objectives

The QISC/CAUMC's effort over the past year resulted in continued progress toward achieving the work plan objectives and other quality and clinical issues that were presented during FY15.

The goals and objectives for FY15, which were determined by the QISC/CAUMC Committee, are listed below. Included below each goal/objective is a brief summary of the progress, the status and the committee's recommendation to continue, revise or discontinue the goal/objective for FY16. Following the review of goals are summaries and graphic information regarding some of our quality activities and satisfaction survey results over the past year.

### Goal 1: Integrate consumer and family member involvement with CAUMC/ QISC efforts.

**1. A. OMFA will collaborate with Quality to validate the value of peer services.**

**Results:** OMFA distributed the survey and the results indicated that not all mental health centers completed the survey. The survey was resent to all mental health centers in order to obtain maximum responses. Once all surveys have been completed, the results will be evaluated, and follow-up activities will be developed. In order to compare the data, the survey will be redistributed anywhere from six months to one year later. The results will be compared in order to determine if an intervention is required. Additionally, over the past year OMFA continued to examine the CROS tool as well as other tools that could potentially be used to assess recovery outcomes; no decisions were finalized

**Committee Recommendation;** Goal 1A will be continued for fiscal year 2016. It was determined that the response rate from some of the mental health centers was lower than expected. The survey was resent to all mental health centers in order to obtain maximum responses. Furthermore, objective 2b which addresses the continued research into a tool to assess recovery outcomes will be continued. The committee recommends that the tool will be decided upon by December of 2015.

**1. B. The QISC/CAUMC Committee will evaluate data related to cultural competency measures.**

**Results:** In order to evaluate data related to cultural competency measures, the QISC/CAUMC committee decided that the question, "Do you feel your counselor is able to meet your cultural, religious and language needs?" will be added to the trending report and reviewed at committee meetings at least annually. This goal has been met.

**Committee Recommendation;** The committee recommends that the question remain on the trending report and that a benchmark be established in FY2016.

**Goal 2: Ensure clinical practice standards and contract requirements, as applicable, are met by providers.**

**2. A. A representative sample of IPN providers will be consistently evaluated against CHP clinical standards, guidelines, and contract requirements in the areas of treatment and discharge planning.**

**Results: Non-CMHC Providers:** Regularly scheduled Non-CMHC Provider audits will continue to occur in order to continue to gain improvement in the audit scores. The results of the FY15 audit demonstrated an increase in Non-CMHC Provider compliance. Continued education is also planned for the upcoming fiscal year. The "Top 5 Diagnosis Report" will continue to be monitored at the QISC/CAUMC meeting. The report has been beneficial and will be modified to include new calculations for the change in unit calculations for MH and SUD services. If needed, providers will be given training on this particular diagnosis if it is seen to become a persistent diagnosis.

**Committee Recommendations:** The committee deemed this goal complete and recommended that the goal be continued through the next fiscal year. Providers will continue to receive regular training. Results will continue to be shared with the committee. Finally, the third target states that QISC will, "continue to monitor the Top 5 Diagnosis report." The committee recommended that a change be made to the report which reflects a change in the way the report is produced.

Accordingly, the report will monitor the change in unit calculation for mental health and substance use services.

**2. B. A representative sample of CMHC providers will be consistently evaluated against CHP clinical standards, guidelines and contract requirements.**

**Results:** In order to continue evaluating coordination of care efforts, monitoring for the CMHCs will continue. A maximum of 15 audit results were submitted quarterly by each CHP mental health center.

**Committee Recommendation:**
The committee recommended continuing goal 2.B. through the next fiscal year. The committee also recommended that an inter-rater reliability audit be set up to confirm the validity of the coordination of care documentation submitted by the CMHC's. At the time of the CMHC contract compliance audits, CMHC's will provide charts for an over read audit.

2.C. **Audits will be conducted on a regular ongoing basis. New audits will be scheduled and implemented and a schedule will be determined.**

**Results:** This goal has been met for FY15. The audits listed on the work plan have been implemented and will continue through the next fiscal year. The aim of the goal is to broaden provider monitoring efforts.

**Committee Recommendation:** The committee recommends continuing this goal for FY16. In addition to the listed audits, routine residential treatment, partial hospitalization and intensive outpatient audits will also be implemented. The results of the audits will continue to be monitored periodically by the QISC/CAUMC committee.

**Goal 3: Systematically analyze and evaluate outcomes data.**

**3. A. QISC will explore options to improve outcomes through education and outreach to members as well as outreach to PCP's who provide services to members with high cost/high risk diagnosis.**

**Results:** The committee received the high cost/high risk diagnosis data report over the last fiscal year. The committee valued using the report to establish meaningful use for their electronic health record.

**Committee Recommendations:** The Committee recommends discontinuing goal 3A. Subsequently, all goals below for the FY16 work plan will be renumbered. For example, goal 4A will become goal 3A. The committee will continue to receive the report..

**Goal 4: Evaluate Clinical/Quality Compliance and Performance**

**4. A. To support the clinical quality improvement process, the QISC, or its designee, will review, evaluate, and/or monitor applicable standards and policies.**

**Results:** On an annual basis, QISC/CAUMC reviews and approves policies and procedures relative to Quality and Clinical Management. Once approved, these policies are submitted to the Class B Board for approval and posted to the website. Policies and procedures were reviewed and evaluated throughout the year

As an accredited site, compliance with URAC standards are continually monitored; training was provided to all new staff. Annual training on identifying and reporting fraud and abuse, URAC standards and other key areas were completed by staff. Areas related to patient safety, including adverse incidents and the annual report on attempted and completed suicides are reviewed and evaluated annually.

**Committee Recommendation:** This goal was met and the committee recommends continuing goal 4.A for FY2016.

**4. B. Review and update CHP Level of Care Guidelines.**

**Results:** An annual review of all existing Guidelines occurred in FY14. The Clinical Peer Advisor and members of the QISC/CAUMC team reviewed, modified and made recommendations for all guidelines throughout the year. QISC/CAUMC approved all guidelines and recommended them to the Class B Board for approval and adoption. The revised guidelines were then posted to the CHP website and disseminated to the mental health centers.

**Committee Recommendation:** This goal was met for FY2015. The committee recommends continuing this goal for FY2016.

**Goal 5: Assure Care Management Department Compliance with Established UM Standards**

**5. A. Ensure consistent application of Clinical LOC guidelines by Care Managers as well as Clinical and Medical leadership.**

**Results:** 100% of all clinicians who took the 2014 annual Utilization Management inter-rater reliability test received individual scores above 80% and were considered passing. The test was also analyzed by discipline and years of clinical experience.

**Committee recommendation:** This will continue to be monitored in FY16

**5. B. Calls are processed efficiently.**

**Results**: Beacon standards for speed of answer and abandonment rates include ASA to be less than 30 seconds and abandonment rates to be less than 3%. The Colorado contract does not specify requirements for answer speed or abandonment. Current data for the year indicate that the average speed of answer was under 7 seconds and the average abandonment rate was less than 1%. The call abandonment rate was similar to the prior year's rate; the average speed of answer was slightly increased, yet still better than the BHO-defined performance standard. Supervision and

close management of department work schedules led to continued excellent performance.

**Committee Recommendation**: This will continue to be monitored in FY16

**5. C. Authorizations are made in timely sequence.**

**Results**: Timeliness of initial authorizations consistently met our high standards. The initial authorization timeliness standard average for the year was 98.75%. Concurrent review authorizations averaged 97.5% for timeliness. Content audits for initial authorization averaged 97.25% for the year; content audits for concurrent authorizations averaged 98%. The minor variances for both timeliness and content for concurrent authorizations were rectified through staff retraining and coaching. The team achieved excellence in their focus on serving our members and providers in a timely and efficient manner when making authorization decisions.

**Committee Recommendation**: This will continue to be monitored in FY16

**5. D. Callers with urgent and emergent needs receive timely services.**

**Results**: Reports were refined throughout the year as data consistently showed no urgent referrals. Referral calls are very rare and staff members are documenting all referrals in the Care Connect system as per their training and protocols. With the number of referral calls being very low, the number of urgent/emergent referral calls has continued to be zero, despite improved documentation. With the retraining complete, the extremely low number of urgent/emergent calls appears to be accurate. Due to the wide array of services available to members at the Mental Health Center level, and the implementation of "warm lines" at multiple centers, it appears that members don't tend to call during urgent/emergent situations, but are instead going to the crisis centers at the local mental health centers and or accessing services through an emergency room. With the increased focus of staff and creation of new positions in the Clinical Department, we will continue to monitor response to urgent/emergent calls. Despite the very low numbers of emergency referral calls received, the Clinical team remains available and focused on making these calls a priority. We will continue to monitor these calls on a quarterly basis.

**Committee Recommendation**: This will continue to be monitored in FY65, with quarterly reports in place.

**5. E. CHP Clinical Policies and Procedures reflect current Corporate and contract standards.**

**Results**: CHP Clinical Policies and Procedures were reviewed/revised in FY2015. The CAUMC committee approved all revised policies, and the Class B Board gave final approval on all policies brought before them in FY2015.

**Committee Recommendation**: This will continue to be monitored in FY16.

**5. F. Clinical training plan is complete as defined in the program description.**

**Results:** 100% of newly hired clinical staff completed their defined training plan and achieved acceptable scores on monitoring audits. When deficiencies were observed, staff was provided with additional coaching or training until consistently accurate performance could be documented.

**Committee recommendation**: This will continue to be monitored in FY16

**5. G. Compliance with URAC standards is maintained.**

**Results**: The Colorado Service Center did receive a URAC site visit in February of 2013, and helped lead Beacon to an achievement of full accreditation through 2016, maintaining our high standards to achieve this accomplishment.

**Committee Recommendation**: Continue to monitor for URAC standard compliance. This will continue to be monitored in FY16.

**Goal 6: Incorporate data based performance targets into the QISC/CAUMC Committee**

**6.A Implement data based performance targets and monitor the implemented change.**

**Results:** The core performance measures continued to be reviewed quarterly during the QISC/CAUMC committee meetings. Targets were established for the measures which relate to the overall 5 BHO weighted average.

**Committee Recommendation:** The committee recommends continuing this goal. Performance issues should continue to be identified. The performance measures will continue to be reviewed at the QISC/CAUMC committee quarterly. As needed, interventions for improvement will be requested if targets are not met for a span of two consecutive quarters.. Goal 6A will now read, "Continue to monitor the data based performance targets."

**6.B Monitor overall BHO performance measures quarterly (.swf file)**

**Results:** This goal was formerly goal 8A. This goal was met in FY15 and will be continued in FY16.

**Committee Recommendation:** The committee recommends continuing this goal. In addition the recommendation is to also identify performance barriers and initiate corrective actions as needed based on performance results.

**Goal 7: Implement new Performance/Quality Improvement Projects**

**7. A.** Develop a new Quality Improvement Project

**Results:**

The current Quality Improvement Project (QIP) focuses on improving the rate of 7-day ambulatory follow-up after inpatient hospitalization for Medicaid Members. The QIP focuses on members who are hospitalized with a mental health diagnosis are a high-risk population, representing the most severely ill psychiatric patient population. Hospitalized Members exhibit the most serious of risk behaviors, including potentially violent behavior directed at themselves or others as well as the inability to provide for their own basic needs. During the hospitalization, the Members' symptoms are stabilized and a plan for continuing care becomes a vital step in the recovery process. An ambulatory follow-up visit with a mental health practitioner after discharge is necessary to ensure that gains made during hospitalization are not lost.

In addition, in August of 2014 the PIP Task group along with the QISC/CAUMC developed a second QIP related to diabetes testing for members currently prescribed atypical antipsychotic medication. The committee sought to focus on integration between behavioral and physical healthcare that would ultimately help to identify and address a potential health issue through facilitating communication between mental and physical health providers.

**Committee Recommendation:** The committee recommended that goal 7A and 7A2 will be continued though the next fiscal year and that the goal be changed to read, "Continue to monitor the current Quality Improvement Projects."

**7. B.** Develop a new Performance Improvement Project.

**Results:**

CHP implemented a new Performance Improvement Project in 2014. This study, assigned by the State of Colorado's Department of Healthcare Policy and Financing (HCPF), is a collaborative, state-wide study designed to achieve the overall goal of improving transitions of care within the healthcare delivery system. The specific focus of the state-chosen topic is the transition of care from the local jail setting to the community. The question CHP is seeking to answer is, "Do targeted interventions increase the percentage of Medicaid Members with a behavioral health diagnosis and who were released from jail having an outpatient follow-up visit within 30 days of the release date?" This study question and methodology were approved by HCPF - 100% of evaluation elements received a score of "Met" in their PIP Validation Study.

CHP is currently collecting inmate booking and release data from the participating jails, and the baseline will be calculated after data collection is complete.

**Committee Recommendation:** The committee recommended continuing this goal and to modify the goal to read, "Continue to monitor the current Performance Improvement Project." Interventions will also be identified and implemented when appropriate.

**Goal 8: Monitor and evaluate BHO Performance Indicators**

**8. A. Monitor overall BHO performance measures quarterly (swf file).**

**Results:** Monitoring of the core performance measures occurs quarterly during the QISC/CAUMC committee. A report is presented at QISC/CAUMC using a rolling annual measure (updated quarterly) to allow for better comparison with fiscal year results. In the past, QISC/CAUMC have seen some downward performance trends in these measures, which has led to the data being analyzed in more detail. The group continues to have regular discussions regarding the data which is presented in this dashboard.

**Committee Recommendation:** This goal was achieved for FY15; the committee determined that the best course of action would be to continue to monitor the performance measures through the

swf file on a quarterly basis and the committee will initiate barrier analysis or a CAP as deemed necessary, based on the identified performance targets. Goal 8A will be moved to goal 6B.

**Goal 9: Monitor and evaluate provider and BHO performance in the delivery of SUD services**

**9.A.** Continue implementing the SUD audits for the Independent Provider Network

**Results:** Beginning in FY15, regularly occurring SUD audits for the IPN network were conducted on a quarterly schedule. Results were calculated and shared with those audited. Furthermore, Medicaid documentation standards training occurred as well as SUD round table discussions which focused on provider questions on the documentation standards.

**Committee Recommendation** The committee recommends that the SUD audits of the independent provider network continue through the next fiscal year and that providers will be monitored for improvements in documentation requirements. The goal for 9A (renumbered to 7A) will now read, "Continue to conduct regular SUD audits for the Independent Provider Network." Additionally, goal 7A2 has been added which now reads, "Providers will continue to be monitored for documentation improvement."

9.B. QISC/CAUMC or another work group will explore options to implement substance use disorder performance measures and monitor BHO performance.

**Results:**

Options were explored in order to determine the best course of action to take in order to implement and monitor substance use disorder performance measures. It was determined that the soundest approach would be to monitor performance measure number 7 (SUD Engagement) through the quarterly review of the performance measure swf file

**Committee Recommendation:** The QISC/CAUMC committee recommended that once the methodology for performance measure number 7 (SUD Engagement) has been finalized that the performance measure will be added to the .swf file and reviewed quarterly.

**Goal 10: QISC/CAUMC will evaluate the FY 2016 work plan progress and review Quality/Utilization Management Program Plans.**

**10. A. QISC/CAUMC will 1) conduct an annual review of work plan goals, 2) conduct annual**

**review, update and approval of Program Description, and 3) QISC and CAUMC will complete an annual evaluation."**

**Results:** This goal has been achieved.

**Committee Recommendation**: This goal was achieved, and will be continued for FY16.

**Goal 11: QISC/CAUMC will work towards the implementation of the integration program into committee efforts.**

**11. A The QISC/CAUMC Committee will work towards implementing the monitoring of the integration program**

**Results:**

**Committee Recommendation:** The QISC/CAUMC Committee recommends the continuation of goal 11A. As integrations efforts continue to expand across the region the committee will continue to support implementation of the integration program through committee efforts. The overall goal will now read, "QISC/CAUMC will continue efforts to incorporate initiatives of the integration program into committee efforts." Correspondingly, goal 11A will now be updated to read, "Support initiatives of the integration program through QISC/CAUMC efforts."

**11. B The QISC/CAUMC committee will look at developing a question for Fact Finders**

**Results:** This goal has been met. A new question for Fact Finders was created and the data will be available in July 2015. The new question read, "In the last 6 months, have any of your counselors asked you questions about your physical health."

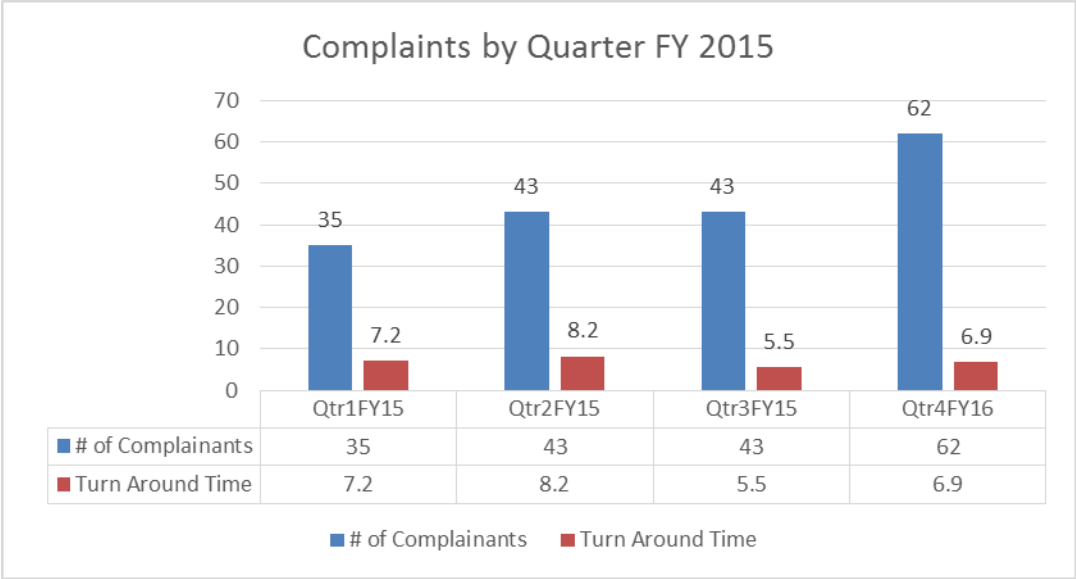
**Committee Recommendation:** The QISC/CAUMC committee will monitor the survey results associated with this question semi-annually. The question will also be added to the trending report. In addition goal 11B will now be updated to read, "The QISC/CAUMC committee will monitor the survey results associated with the new Fact Finders question."

**SUMMARY OF MONITORING AND SATISFACTION SURVEY MEASURES**

**Complaints and Grievances**

The total number of complaints received in FY15 was 306. This is an increase compared to the 197 complaints reported in FY14. In FY14 the average complaint resolution time was 4.6 days. This time increased slightly in FY15 to 6.9 days. The current standard for complaint resolution is 15 business days.

Complaint data is trended by categories and resolution times quarterly throughout the year. The volume of complaints by category and resolution times is reviewed by QISC/CAUMC and the Office of Member and Family affairs every quarter. An annual report is also produced and presents a more in-depth review.




**Fact Finders Satisfaction Survey Information & Member Satisfaction**

The Fact Finders Survey is a telephone survey completed by a vendor (Fact Finders, Inc.) contracted by Beacon. Fact Finders' conducts telephone calls quarterly to a sample of members who utilized services in the prior three-month period. The sample of clients number approximately 400 each year. CHP receives semi-annual reports from Fact Finders that consist of aggregate CHP data for calls conducted during the six-month timeframe. CHP also receives an annual (calendar year) report from Fact Finders with results by mental health center and aggregate results for the contracted provider network. Specific Fact Finders Survey results by CMHC and independent provider (IPN) networks for calendar year 2014 begin on page 34 of this document.

Comparing survey results from calendar year 2013 to 2014 for CHP, member satisfaction remained consistent. The CHP performance standard for this indicator is 90% and based on the calendar year 2014 data, CHP's satisfaction survey results indicated that 90.0% of respondents were satisfied with the services they received. This is a slight decrease from the previous calendar year satisfaction rate of 93.3% .However, the performance standard for this survey question continues to meet or exceed the established benchmark.

Member satisfaction with overall quality of services received from their counsellor averaged 88.8% for

CHP in calendar year 2014. This represents a slight increase when comparing the ratings given in CY2013 when the overall satisfaction survey response rate was 87.3%.

Responses to the question, "Thinking back to your first appointment, did you get an appointment as soon as you wanted," indicated that members remain satisfied with receiving appointments as soon as they wanted. Also, it is difficult to establish whether or not the appointment offered within seven business days did not meet the members' expectations for getting an appointment "as soon as you wanted." As there is no way to tell when a respondent's first appointment occurred, it is challenging to know whether the request for an appointment was for a specialized therapist, service or special program, etc., or how much time elapsed between the request for initial appointment and the survey call.

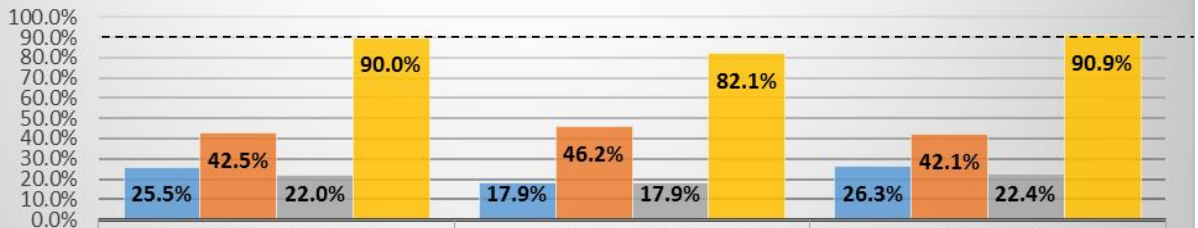
A slight increase occurred from 2013 to 2014 for the survey question measuring improvement in general condition. In -CY2013, 63% indicated they are feeling "better" than a year ago. - Results for CY2014 remain higher than the CHP performance goal of 55%. The CHP overall results for 2014 are: Better 67.1%, About the Same-25.7% and Worse 7.2%.

When comparing survey responses from clients seen in the CMHCs and by the independent provider network (IPN) –it is important to note that the number of CMHC clients responding is higher (approximately 361) than IPN clients (approximately 39). CMHC strengths included: satisfaction with the quality of services,, the counselor was just right for their needs, felt the counselor was able to meet their cultural, religious and language needs, their problems and symptoms had improved and counselors involved them more in decisions about their care.

For those respondents receiving services from the IPN, clients indicated they felt the office location was convenient for them, are better able to handle day to day activities as a result of counseling received, helped more by the counseling they received, also felt the office location was convenient. Additionally, members receiving services from both the CMHC and IPN felt strongly that providers met their cultural needs and protected their confidential information.

Some of the differences between the CMHC and IPN responses may be attributed to the fact that clients receiving services at the CMHCs may be engaged in a broader continuum of services than are available through the IPN.

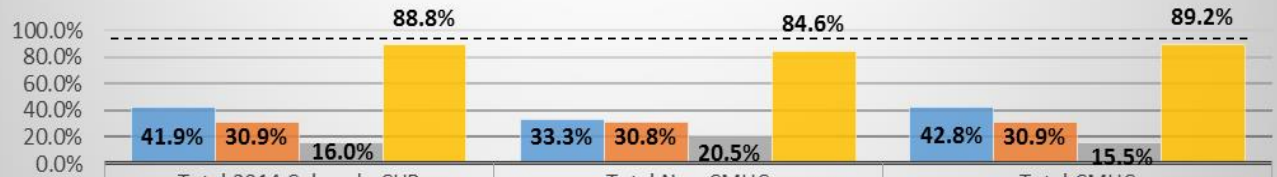
## Overall, how satisfied are you with the mental health services of CHP (Performance Standard = 90%)



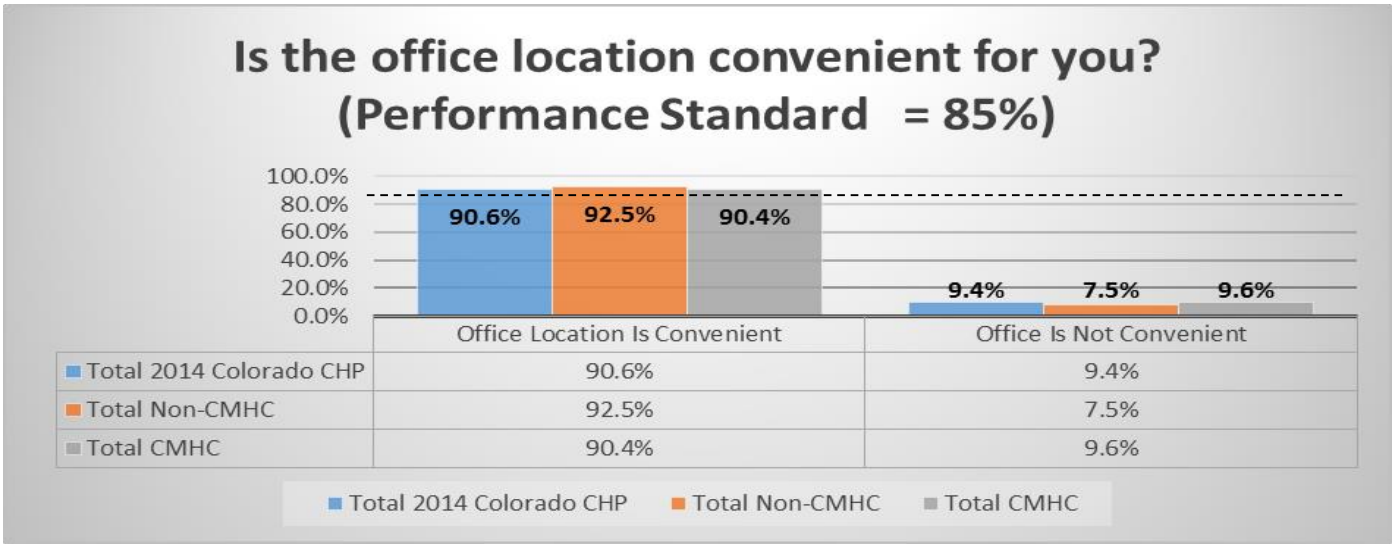

| | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|
| Completely Satisfied | 25.5% | 17.9% | 26.3% |
| Very Satisfied | 42.5% | 46.2% | 42.1% |
| Somewhat Satisfied | 22.0% | 17.9% | 22.4% |
| Total % | 90.0% | 82.1% | 90.9% |



## Overall, how would you rate the quality of services you have received from your counselor? (Performance Standard = 90%)




| | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|
| Excellent | 41.9% | 33.3% | 42.8% |
| Very Good | 30.9% | 30.8% | 30.9% |
| Good | 16.0% | 20.5% | 15.5% |
| Total % | 88.8% | 84.6% | 89.2% |


Is the office location convenient for you?
(Performance Standard = 85%)
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
90.6%
92.5%
90.4%
9.4%
7.5%
9.6%
Office Location Is Convenient
Office Is Not Convenient
Total 2014 Colorado CHP
90.6%
9.4%
Total Non-CMHC
92.5%
7.5%
Total CMHC
90.4%
9.6%
Total 2014 Colorado CHP
Total Non-CMHC
Total CMHC

## QUESTIONS REGARDING COUNSELOR RATING

**Do you feel your counselor is able to meet your cultural, religious and language needs?**

| Meets Cultural, Religious, and Language Needs | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Counselor Meets Cultural Needs | | 95.5% | 92.3% | 95.8% |
| | (n) | 380 | 36 | 344 |
| Counselor Does Not Meet Cultural Needs | | 4.5% | 7.7% | 4.2% |
| | (n) | 18 | 3 | 15 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 398 | 39 | 359 |
| No Opinion | (n) | 8 | 1 | 7 |

**Do you feel your counselor protects your confidentiality?**

| Protection of Confidential Information | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Counselor Protects Confidential Information | | 96.8% | 97.5% | 96.7% |
| | (n) | 390 | 39 | 351 |
| Counselor Does Not Protect Confidential Information | | 3.2% | 2.5% | 3.3% |
| | (n) | 13 | 1 | 12 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 403 | 40 | 363 |
| No Opinion | (n) | 3 | 0 | 3 |

**Has your counselor involved you in decisions about your care?**

| Involved in Decision-Making About Care | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Member Involved in Care Decisions | | 91.4% | 87.5% | 91.9% |
| | (n) | 362 | 35 | 327 |
| Member Not Involved in Care Decisions | | 8.6% | 12.5% | 8.1% |
| | (n) | 34 | 5 | 29 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 396 | 40 | 356 |
| No Opinion | (n) | 10 | 0 | 10 |

**Has your counselor helped you make needed changes in your life?**

| Helped with Needed Changes | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Counselor Helped with Needed Changes | | 86.2% | 81.6% | 86.6% |
| | (n) | 336 | 31 | 305 |
| Counselor Did Not Help with Needed Changes | | 13.8% | 18.4% | 13.4% |
| | (n) | 54 | 7 | 47 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 390 | 38 | 352 |
| No Opinion | (n) | 16 | 2 | 14 |

**Do you feel your counselor is just right for your needs?**

| Just Right for Needs | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Counselor Is Just Right for Needs | | 86.2% | 80.6% | 86.8% |
| | (n) | 338 | 29 | 309 |
| Counselor Not Just Right | | 13.8% | 19.4% | 13.2% |
| | (n) | 54 | 7 | 47 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 392 | 36 | 356 |
| No Opinion | (n) | 14 | 4 | 10 |

**QUESTIONS RELATED TO OUTCOMES OF SERVICES**

**How much were you helped by the counseling you got? A great deal, somewhat, not much**

| Treatment Helped: | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| A Great Deal | | 64.3% | 61.5% | 64.6% |
| | (n) | 256 | 24 | 232 |
| Somewhat | | 27.1% | 28.2% | 27.0% |
| | (n) | 108 | 11 | 97 |
| Not Much At All | | 8.5% | 10.3% | 8.4% |
| | (n) | 34 | 4 | 30 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 398 | 39 | 359 |

**Compared to a year ago are you more confident in your ability to handle day-to-day activities?**

| Handle Day-to-Day Activities | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Yes, Better Able | | 77.6% | 80.8% | 77.2% |
| | (n) | 204 | 21 | 183 |
| No, Not Better Able | | 22.4% | 19.2% | 22.8% |
| | (n) | 59 | 5 | 54 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 263 | 26 | 237 |

**Have you talked to a peer specialist?**

| Talked to Peer Specialist | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Talked to Peer Specialist | | 17.8% | 17.4% | 17.8% |
| | (n) | 43 | 4 | 39 |
| Have Not Talked to Peer Specialist | | 82.2% | 82.6% | 82.2% |
| | (n) | 199 | 19 | 180 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 242 | 23 | 219 |

**Do you go to activities such as a drop-in center, self-help group, workshop or class?**

| Participation in Activities | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Participate in Activities | | 24.3% | 15.4% | 25.2% |
| | (n) | 68 | 4 | 64 |
| Do Not Participate in Activities | | 75.7% | 84.6% | 74.8% |
| | (n) | 212 | 22 | 190 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 280 | 26 | 254 |

## QUESTIONS RELATED TO COORDINATION OF CARE

**Is your primary care physician aware that you have received mental health services?**

| PCP Awareness | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Aware | | 84.2% | 82.5% | 84.4% |
| | (n) | 342 | 33 | 309 |
| Not Aware | | 8.6% | 10.0% | 8.5% |
| | (n) | 35 | 4 | 31 |
| No Opinion | | 7.1% | 7.5% | 7.1% |
| | (n) | 29 | 3 | 26 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 406 | 40 | 366 |

## Questions Related to Access

**Can you get to the counselors office in less than 30 minutes?**

| Travel Time To Counselor | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Can Get to Office in Less than 30 Minutes | | 86.3% | 87.2% | 86.2% |
| | (n) | 347 | 34 | 313 |
| Cannot Get to Office in Less than 30 Minutes | | 13.7% | 12.8% | 13.8% |
| | (n) | 55 | 5 | 50 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 402 | 39 | 363 |

**Thinking back to your first appointment with the counselor, Was this first appointment within the last year?**

| Length of Time with Counselor | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| First Appointment within Last Year | | 65.4% | 73.7% | 64.5% |
| | (n) | 257 | 28 | 229 |
| First Appointment Longer than 1 Year | | 34.6% | 26.3% | 35.5% |
| | (n) | 136 | 10 | 126 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 393 | 38 | 355 |

**Did you get an appointment as soon as you wanted? (References question above)**

| First Appointment As Soon As Desired | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Got First Appointment As Soon As Desired | | 86.0% | 87.2% | 85.9% |
| | (n) | 339 | 34 | 305 |
| Did Not Get Desired First Appointment | | 14.0% | 12.8% | 14.1% |
| | (n) | 55 | 5 | 50 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 394 | 39 | 355 |

**Were you offered your first appointment within 10 days of your call?**

| First Appointment Within Ten Days | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Offered Appointment Within 10 Days | | 80.0% | 83.3% | 79.6% |
| | (n) | 284 | 30 | 254 |
| Not Offered Appointment Within 10 Days | | 20.0% | 16.7% | 20.4% |
| | (n) | 71 | 6 | 65 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 355 | 36 | 319 |
| No Opinion | (n) | 51 | 4 | 47 |

## QUESTIONS RELATED TO HOSPITAL SERVICES (SATISFACTION WITH CARE)

**Are you satisfied with the number of days that ValueOptions authorized for you to stay in the hospital?**

| Satisfaction with Number of Hospital Days | | Total 2014 Colorado CHP | Total Non-CMHC | Total CMHC |
|---|---|---|---|---|
| Satisfied | | 80.0% | 60.0% | 82.9% |
| | (n) | 32 | 3 | 29 |
| Not Satisfied | | 15.0% | 40.0% | 11.4% |
| | (n) | 6 | 2 | 4 |
| No Opinion | | 5.0% | 0.0% | 5.7% |
| | (n) | 2 | 0 | 2 |
| | Total %: | 100.0% | 100.0% | 100.0% |
| | (N): | 40 | 5 | 35 |